MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

83-a

08200

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
County Allegany
City or town Mt. Savage
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Foundry Row
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 66 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Mt. Savage Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Foundry Row
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Arthur Randolph Baker
3. (b) Social Security Number 218-07-3073

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Mary T. Bridges
6(c) If alive, give age 56 years
7. Birth date of deceased (mo., day, yr.) June 13, 1880
8. AGE: Years 66 Months 1 Days 17 If less than one day ___ hrs. ___ min.
9. Birthplace Mt Savage, Allegany Co, Md (Town, county, and state)
10. Usual occupation Coal Miner
11. Industry or business Coal Mines
FATHER 12. Name Louis Baker
13. Birthplace England
MOTHER 14. Maiden name Mary K. Hostetter
15. Birthplace Pennsylvania
16. Informant Louis R. Baker
Address Mt. Savage Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 14, 1940 (month) (day) (year)
Cemetery or crematory Episcopal
Location Mt. Savage Md
18. Funeral director Jacob Hafer
Address Frostburg Md.
19. Aug. 13 1940 (Date rec'd by registrar) Nancy H. Rae Dept. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1940, at 6:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sudden 19 Death 19
and that I last saw h alive on 19
Immediate cause of death Cerebral hemorrhage
Due to Arteriosclerosis
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION
Sudden
Onset
?

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W O McLane Jr MD M. D. or other
Address Frostburg Md Date signed 8-12-40

Dr McLane

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 4 1940
BUREAU U. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-B)

08201

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 weeks

Hospital, institution, or street address where death occurred: 1008 Sibadeo Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland Md (If outside city or town limits, write RURAL and give nearest town)

Street No. 1008 Sibadeo Lane (If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: John W Bell

3.(b) Social Security Number: None

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Barbara Bell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 29, 1853

8. AGE: Years 86 | Months 9 | Days 11 | If less than one day ..... hrs. ..... min.

9. Birthplace: Orleans Md (Town, county, and state)

10. Usual occupation: Watchman

11. Industry or business: Rail Road

FATHER: 12. Name: Unknown

13. Birthplace:

MOTHER: 14. Maiden name:

15. Birthplace:

16. Informant: Jesse Bell

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 13 1940 (month) (day) (year)

Cemetery or crematory: Greenmount

Location: Cumberland

18. Funeral director: Jacob Hofer

Address: Cumberland

19. Aug. 13 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 10 1940 at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 1940, to Aug 10 1940 and that I last saw him alive on Aug 9 1940

Immediate cause of death	DURATION
Uremia Coma	5 days
Due to Chronic nephritis	2 yrs
Due to Arteriosclerosis	2 yrs
Other conditions	

(Include pregnancy within 8 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: Thos. H. Kroon M. D. or other

Address: Cumberland Md Date signed: Aug 12-40

VS A15 (T) (1) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(46-J)

08202

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 24 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town LONACONING (If outside city or town limits, write RURAL and give nearest town)

Street No. 43 CHURCH ST. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MRS. FLORENCE BLAND

3.(b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife ALBERT H. BLAND

6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) FEBRUARY 26, 1882

8. AGE:

Years	Months	Days	If less than one day
58	5	5	hrs. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name LEWIS KALLMYER (DECEASED)
13. Birthplace GERMANY

MOTHER
14. Maiden name Ellen Wetzel
15. Birthplace Bloomington, Md.

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Aug 4. 1940 (month) (day) (year)

Cemetery or crematory Oak Hill Cem

Location Lonaconing Md

18. Funeral director David S. Boal

Address Lonaconing Md.

19. Aug 1, 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 1 1940, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JULY 8, 1940, to AUG. 1, 1940 and that I last saw her alive on AUG. 1, 1940

Immediate cause of death Carcinomatosis

Due to Adeno carcinoma lung and abdominal contents - Original site not known

Due to

Other conditions

DURATION ?

(Include pregnancy within 3 months of death)

Major findings of operations Carcinomatosis of abdominal cavity Date of op. July 10, 1940

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. M. Wilson M.D. M. D. or other

Address Cumberland Md Date signed 8-1-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR. WILSON

RECEIVED
SEP 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

08203

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:

County Allegany

City or town Mt Savage

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Mt Savage Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Robert Levi Blank

3. (b) Social Security Number

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced Sing Ce

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 24 - 1940

8. AGE: Years | Months | Days | If less than one day hrs. 20 min.

9. Birthplace Mt Savage Md (Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name Francis E. Blank

13. Birthplace Mt Savage Md

MOTHER 14. Maiden name Mary Catharine Hunt

15. Birthplace Cresaptown Md

16. Informant Francis E. Blank

Address Mt. Savage Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 24 - 1940 (month) (day) (year)

Cemetery or crematory Episcopal Cemetery

Location Mt Savage Md

18. Funeral director J. J. Durst

Address Frostburg Md

19. 8/24 1940 (Date rec'd by registrar) H. J. Bostetter M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24 1940, at 9.40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 24 1940, to Aug 24 1940 and that I last saw him alive on Aug 24 1940

Immediate cause of death Premature Birth

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. J. Bostetter M.D. M. D. or other

Address Mt Savage Md Date signed 8/24/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (161-a)

08204

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany County

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hosp.

How long in hospital or institution? 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 226 N. Lee St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: BABY GIRL BROWN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 22, 1940

8. AGE: Years	Months	Days	If less than one day
NB			1 hrs. 10 min.

9. Birthplace: Memorial Hospital
(Town, county, and state)
Cumberland, Md.

10. Usual occupation: None

11. Industry or business: None

FATHER
12. Name: WILMER BROWN
13. Birthplace: Maryland

MOTHER
14. Maiden name: Kathleen Bartolotta
15. Birthplace: West Virginia

16. Informant: Memorial Hospital
Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 23, 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Cumberland Md.

18. Funeral director: V. L. Tempereur

Address: 202 Green St. Cumberland

19. Aug 23 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 22, 1940 19 ..., at 4:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 22 1940, to Aug 22 1940 and that I last saw her alive on Aug 22 1940

Immediate cause of death: Congenital Atelectasis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Arthur F. Jones M.D. M. D. or other

Address: 40 N. Liberty St. Date signed: 8-22-40

DR. A. JONES

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

08205

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 302 Pennsylvania Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland, Md (If outside city or town limits, write RURAL and give nearest town)

Street No.: 302 Pennsylvania Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Isabelle Ann Burdett

3.(b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) ~~Single~~, married, ~~widowed, or divorced~~: married

6.(b) Name of husband ~~or wife~~: Thomas Burdett

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 22 1865

8. AGE: Years 76 | Months 8 | Days 2 | If less than one day ..... hrs. ..... min.

9. Birthplace: Canada (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Crawford
13. Birthplace: not known

MOTHER
14. Maiden name: not known
15. Birthplace: "

16. Informant: Thomas Burdett

Address: 302 Pennsylvania Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 27 1940 (month) (day) (year)

Cemetery or crematory: Hill Crest

Location: Cumberland, Md

18. Funeral director: Louis Stein Inc

Address: Cumberland, Md

19. Aug. 26 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 24 1940, at 69 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 24 1940 to Aug 24 1940 and that I last saw h... alive on Aug 24 1940

Immediate cause of death: Coronary Occlusion — DURATION: 1/2 day

Due to: Arterio-sclerosis — 4 yrs

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: 133 Va Ave Date signed: 8/24

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

08206

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Alleganys

City or town: Cumberland Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 hrs and 59 min

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Alleganys

City or town: Cumberland Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 223 Ground Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Baby Collins.

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 18, 1940

8. AGE:

Years	Months	Days	If less than one day
			5 hrs. 59 min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: Newborn (Premature)

11. Industry or business

FATHER

12. Name: Wilbur Collins

13. Birthplace: Md Cumberland

MOTHER

14. Maiden name: Nellie Decker

15. Birthplace: Ridgeley, West Virginia

16. Informant: Mr Wilbur Collins

Address: Cumb. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 19 40 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md

18. Funeral director: Louis Stein Sons

Address: Cumberland Md

19. Aug. 19 19 40 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 18 1940, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 18 1940, to Aug 18 1940

and that I last saw h.. alive on Aug 18 1940

Immediate cause of death	DURATION
Premature Birth 6½ mos.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: P. C. Bowers M.D. M. D. or other

Address Cumberland Md Date signed 8-19-40

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-B)

CERTIFICATE OF DEATH

08207

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26
Hospital, institution, or street address where death occurred: 516 Avondale Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 516 Avondale Ave
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME Lillie Blanche Cosgrove

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Morris S. Cosgrove
6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) July 10, 1890

8. AGE: Years 50 | Months 1 | Days 5 | If less than one day ... hrs. ... min.

9. Birthplace Cumberland Md
(Town, county, and state)
10. Usual occupation Housekeeper
11. Industry or business At Home
FATHER 12. Name Amos R. Smith
13. Birthplace Artemus Pa.
MOTHER 14. Maiden name Annie P. Thompson
15. Birthplace Flintstone Md
16. Informant Miss Marion Smith
Address Cumberland Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 19 1940 (month) (day) (year)
Cemetery or crematory Hillcrest Cem
Location Cumberland Md
18. Funeral director Jacob Hoper
Address Cumberland Md
19. Aug 19 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15- 1940, at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1940, to Aug. 15 1940 and that I last saw her alive on Aug. 10 - 1940

Immediate cause of death	DURATION
Carcinomatosis of abdomen	
Due to Carcinoma of	
Due to uterus.	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operation None; Radium Had been used Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Wm. F. Williams M. D. or other
Address Cumberland Date signed 8-17-40

RECEIVED
SEP 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08208

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg, Md.
(If outside city or town limits, write RURAL or NEAR and give town)
Street address, hospital, or institution: 86 Bowery St.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL or NEAR and give town)
Street No.: 86 Bowery St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME James Ellsworth Crumpf

3. (b) Social Security Number none

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mary Jane Crumpf
6 (c) If alive, give age: 76 years
7. Birth date of deceased (mo., day, yr.): May 5, 1863
8. AGE: Years: 77 Months: 3 Days: 11 If less than one day: hrs. min.
9. Birthplace: Frostburg Allegany Cty. Md.
(Town, county, and state)
10. Usual occupation: Foreman
11. Industry or business: Power Company
FATHER 12. Name: William H. Crumpf
13. Birthplace: England
MOTHER 14. Maiden name: Elizabeth Evans
15. Birthplace: England
16. Informant: Taylor Crumpf
Address: Frostburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 19, 1940 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg Md.
18. Funeral director: J. J. Hurst
Address: Frostburg Md.
19. Aug. 19 1940 (Date received by registrar) Maudy H. Rae Dept. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 17 1940, at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1940, to Aug 19 1940, and that I last saw h~~im~~ alive on Aug 19 1940

DURATION

Immediate cause of death: Chr myocarditis
Due to: arteriosclerosis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: A M Earle Jr MD (M. D. or other)
Address: Frostburg Md. Date signed: 8-19-40

RECEIVED
SEP 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08209

13-C

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 629 Lincoln St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME WILLIAM CUBBAGE

3.(b) Social Security Number None

4. Sex	5. Color or race	b.(a) Single, married, widowed, or divorced
Male	W	Married

6.(b) Name of husband or wife: Ruth Jay

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): 8/26/84

8. AGE:

Years	Months	Days	If less than one day
56	0	5	...hrs. ...min.

9. Birthplace: Keyser W. Va. (Town, county, and state)

10. Usual occupation: Policeman

11. Industry or business: City of Cumberland

FATHER 12. Name: Benjamin Franklin Cubbage

13. Birthplace: W. Va.

MOTHER 14. Maiden name: Susan Foster

15. Birthplace: W. Va.

16. Informant: Ruth Jay Cubbage

Address: 629 Lincoln St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/3/40 (month) (day) (year)

Cemetery or crematory: Hillcrest Cem.

Location: Cumberland, Md.

18. Funeral director: Louis Stein Inc.

Address: Cumberland, Md.

19. Sept. 3 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 31 1940 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 28 1940, to Aug 31 1940

and that I last saw h... alive on Aug 31 1940

Immediate cause of death: Tuberculosis Laryngeal

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

	DURATION
	...
	...
	...
	...
	...

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. P. Franklin M.D.

M. D. or other

Address: Date signed

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

08210

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs.

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? Yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 124 N. Centre St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Edward Franklin Curtis

3. (b) Social Security Number 213-18-2994

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Jan 1 1882

8. AGE: Years 58 | Months 7 | Days 14 | If less than one day ... hrs. ... min.

9. Birthplace: Charlotte Va.
(Town, county, and state)

10. Usual occupation: Clerk.

11. Industry or business: Restaurant

FATHER
12. Name: Charles L Curtis
13. Birthplace: Va.

MOTHER
14. Maiden name: Lena V Yew
15. Birthplace: Va.

16. Informant: Mrs Blanche M. Burrall. Bilateral Pyelonephritis, diverticular of bladder.

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 17 40 (month) (day) (year)

Cemetery or crematory: Zion Mem. Park.

Location: near Cumberland Md

18. Funeral director: Louis Stein Inc

Address: Cumberland.

19. Aug 17 1940 (Date rec'd by registrar) J. P. Franklin, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 15, 1940, at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1940, to Aug 14 1940 and that I last saw him alive on Aug 14 1940

Immediate cause of death: Pyelonephritis — DURATION: 7 days

Due to: Ascending infection

Due to: Severe infection of bladder

Other conditions: Retention of urine from prostatic enlargement and multiple diverticula of bladder and severe infection of bladder

(Include pregnancy within 3 months of death)

Major findings of operations: Foul infection of bladder, prostatic obstruction

Date of op. Prostatic resection July 30, 1940

Histopathy results: Pyelonephritis, diverticular of bladder

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: R. A. Trevaskis MD, M. D. or other

Address: Cumberland, Md Date signed: Aug 15-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (182)

CERTIFICATE OF DEATH

08211

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 1- Cumberland St. - metzger Sand Co.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County Mineral

City or town Ridgeley

(If outside city or town limits, write RURAL and give nearest town)

Street No. 170 main St Ridgeley West Va

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Earl W. Dailey

3.(b) Social Security Number 214-07-1131

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of ~~husband~~ or wife Ida Lucille Edenhart

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1891

8. AGE: Years	Months	Days	If less than one day
49	9	15	hrs. min.

9. Birthplace Martinsburg West Va.

(Town, county, and state)

10. Usual occupation Labor - metzger Sand Co.

11. Industry or business 1 Cumberland St - Cumberland, md

FATHER 12. Name Charles Dailey

13. Birthplace West Va.

MOTHER 14. Maiden name Not known.

15. Birthplace "

16. Informant Ida Lucille Dailey

Address 170 main St - Ridgley West Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 26 1940 (month) (day) (year)

Cemetery or crematory Hill Crest

Location Cumberland, md

18. Funeral director Louis Stein Inc

Address Cumberland, md.

19. Aug 26 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23rd., 1940, at about 2.30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Suffocation	
Due to	
Due to	
Other conditions	

(Include pregna... within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 8/23/40

Where did injury occur? Cumberland, Allegany, Maryland. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Sand Works.

Means of injury suffocated by sand Injured at work? yes

23. SIGNATURE Bruce H. Lemon M. D.

M. D. or other

Address Cumberland, Maryland. Date signed 8/24/40

Deputy Medical Examiner - Allegany Co.

RECEIVED
AUG 27 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (151)

08212

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 years

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 7 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 231 Oak St.
(If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME Elizabeth Di Gilarmo

3. (b) Social Security Number None

4. Sex F.

5. Color or race W

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Raymond Di Gilarmo

6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) March 29, 1897

8. AGE: Years 43 Months 5 Days 0 If less than one day ..... hrs. ..... min.

8. Birthplace Mintorna, Italy
(Town, county, and state)

10. Usual occupation House Keeper

11. Industry or business At home

FATHER
12. Name De Cicco
13. Birthplace Italy

MOTHER
14. Maiden name Not Known
15. Birthplace Not Known

16. Informant Albert Di Gilarmo

Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 31, 1940 (month) (day) (year)

Cemetery or crematory St. Patrick's Cemetery

Location Cumberland, Md.

18. Funeral director Jacob Hafer

Address Cumberland, Maryland

19. Aug. 30 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29 1940 at 11 15/A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1940, to Aug 29 1940 and that I last saw her alive on 8/29/40 19

Immediate cause of death Diffuse cellulitis of scalp.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations Carbuncle of face spread to scalp. Date of July 1940

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John K Rynn M.D. M. D. or other

Address Cumberland Md. Date signed 8/30/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-P)

CERTIFICATE OF DEATH

08213

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 487 Fort Ave

Stay in hospital or Inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 487 Fort Ave

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Isaac C. Divelbiss

3. (b) Social Security Number: 220-10-2567

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B (b) Name of husband or wife: Annie Kearshner

6(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): March 15 1885

8. AGE: Years: 55 Months: 5 Days: 3 If less than one day: hrs. min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: Thos. Divelbiss

FATHER 13. Birthplace: West Virginia

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: West Virginia

16. Informant: Mrs. Isaac Divelbiss

Address: 487 Fort Ave., City

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 21, 1940 (month) (day) (year)

Cemetery or crematory: Mt. Hermon Cem.

Location: Cumberland, Md.

18. Funeral director: C. L. Lemperenes

Address: Cumberland, Md.

19. Aug. 21, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 18 1940, at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1940, to Aug 18 1940, and that I last saw him alive on July 31 1940

Immediate cause of death	DURATION
Chronic Endocarditis	2 yrs
Due to Chronic Nephritis	3 yrs
Due to Arteriosclerosis	7 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Thos A Lemon M. D. or other

Address: Cumberland Md Date signed: Aug 19 1940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

08214

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Illinois County

City or town Danville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1603 Fairchild St.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME
Mrs. Edith DoBell

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Mr. Fred DoBell

6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Feb. -- 1903

8. AGE:

Years	Months	Days	If less than one day
38	5		hrs. min.

9. Birthplace Danville Ill.
(Town, county, and state)

10. Usual occupation Wire Rope Walker

11. Industry or business Carnival

FATHER
12. Name Earl Lockhart
13. Birthplace Ill.

MOTHER
14. Maiden name Amie Jackison
15. Birthplace Ill.

16. Informant Mr. Fred DoBell
Address 1603 Fairchild St. Danville Ill.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Aug. 3, 1940
(month) (day) (year)

Cemetery or crematory Zion Memorial Cem.

Location Bedford Road

18. Funeral director J. C. Wolford
Address Cumberland, Md.

19. Aug. 2, 1940 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 1940, at 12:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11:30 P.M. Aug 1 1940, to 12:50 Aug 2 1940
and that I last saw her alive on Aug 2 1940

Immediate cause of death Fracture of skull, crushed chest, hemothorax, compound fracture of left forearm

Due to

Due to Fall from tight rope

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Accident Date of Aug 1-40

Where did injury occur? Cumberland Allegany Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Carnival

Means of injury Fall from rope Injured at work?

23. SIGNATURE A. E. Enfield M. D. or other

Address Cumberland Date signed Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1940
BUREAU V. S.

Outside of City Limits

08215

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Bowmans Addition Cumberland rural
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Bowmans Addition Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Near Cumberland
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Ezra C. Dorsey

3. (b) Social Security Number 220-07-6520

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lola Dorsey

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1891.

8. AGE: Years 48 Months 8 Days 2 If less than one day hrs. min.

9. Birthplace Green Spring W. Va.
(Town, county, and state)

10. Usual occupation Salesman

11. Industry or business Nursery Stock

FATHER
12. Name Wm. M. Dorsey
13. Birthplace W. Va.

MOTHER
14. Maiden name Martha Morrissey Morrissey
15. Birthplace W. Va.

16. Informant Mrs. Lola Dorsey

Address Bowmans Addition Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 20, 1940 (month) (day) (year)

Cemetery or crematory Davis Memorial Cem.

Location Old Town Road

18. Funeral director J. C. Wolford

Address Cumberland, Md.

19. Aug. 19, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17th., about 1940, at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,

and that I last saw h alive on 19 .

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy none

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Pinner H. Corson, M.D.
M. D. or other

Address Cumberland, Maryland. Date signed 8/18/40

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 24 1940
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-E)

CERTIFICATE OF DEATH

08216

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Frostburg Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 6 Bowery St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) all her life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Borden Mine Ward No. Rural

(If outside city or town limits, write RURAL NEAR and give town)

Street No. near Frostburg

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Dora Doral Drummond

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife James Drummond

6(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Dec. 31 st. 1890

8. AGE:

Years	Months	Days	If less than one day
49	7	8	hrs. min.

9. Birthplace Zihlman Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name John Leichey

13. Birthplace Mt. Savage Md.

MOTHER

14. Maiden name Lizzie Evans

15. Birthplace Ebbyland

16. Informant James Drummond

Address Borden Mine, Md.

17. Burial Date thereof Aug 12 1940

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany Cem.

Location Frostburg Md

18. Funeral director Sarah E Kaufman

Address Frostburg, Md.

19. Aug 12 1940 Nancy N. Rae Registrar Asst.

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9 1940, at 12:00 M noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1940, to Aug 9 1940, and that I last saw h-er alive on Aug 9 1940.

Immediate cause of death	DURATION
Carcinoma of Sigmoid	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings: Of operations Carcinoma of Sigmoid

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm N Lane Jr MD M. D. or other

Address Frostburg Md Date signed 8-9-40

RECEIVED
SEP 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (112)

CERTIFICATE OF DEATH

08217

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: West Virginia County: Mineral
City or town: Piedmont
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME
MRS. ALMA ENOS

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Charles Enos
6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): July 27, 1900

8. AGE: Years	Months	Days	If less than one day
40	0	8	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Louis Mitter
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Anna Barracks
15. Birthplace: Maryland

16. Informant: Charles B. Enos
Address: Piedmont, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 8-1940 (month) (day) (year)
Cemetery or crematory: Phlox
Location: Westernport Md.

18. Funeral director: David S. Boal
Address: Westernport, Md.

19. Aug. 7, 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5, 1940 at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-5- 1940, to 8-5- 1940 and that I last saw h[illegible] alive on 8-5- 1940

Immediate cause of death	DURATION
Intractable asthma	One day
Due to Im Hospital	
Due to 3 hours.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Wm. F. Williams M. D. or other
Address: Cumberland Date signed: 8-6-40

RECEIVED
SEP 6 1940
BUREAU V. S.

Within Corp. Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(8)

08218

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg, Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: ~~196 Railroad St~~

Stay in hospital or inst. (yrs., or mos., or days) Miners Hospital

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Frostburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Infant Evans

3. (b) Social Security Number

4. Sex unable to determine

5. Color or race white

6. (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Stillborn

8. AGE: Years | Months | Days | If less than one day hrs. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Shannon Evans
13. Birthplace Md.

MOTHER
14. Maiden name Sadie ~~Bittinger~~ Platter
15. Birthplace Grantsville, Md.

16. Informant Shannon Evans

Address 196 Railroad St. Frostburg, Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof Aug. 15, 1940 (month) (day) (year)

Cemetery or crematory Eckhart Cemetery

Location Eckhart, Md.

18. Funeral director Jacob Wafer

Address Frostburg, Md

19. Aug. 13 1940 (Date rec'd by registrar) Nancy H. Roe Dept. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1940, at 6 P.M. 30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,

and that I last saw h alive on 19

Immediate cause of death Stillborn (full-term). Mal-formed foetus.

Due to unable to deliver entire body before

Due to death of mother therefore unable to

Other conditions determine sex.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. Diehl, M. D.
M. D. or other

Address Frostburg, Md. Date signed 8/13/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (147-A)

CERTIFICATE OF DEATH

08219

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Frostburg, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 196 Railroad St Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 11 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Frostburg, Md Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 196 Railroad St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Sadie Gertrude "Platter" Evans.

3. (b) Social Security Number none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	married.

6 (b) Name of husband or wife Shannon F. Evans

6(c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Sept 23, 1907

8. AGE: Years 32 | Months 11 | Days 19 | If less than one day ____ hrs. ____ min.

9. Birthplace Garrett, Somerset Co, Pa.
(Town, county, and state)

10. Usual occupation House work At Home

11. Industry or business

FATHER 12. Name Wm. Platter.

13. Birthplace Grantsville, Md.

MOTHER 14. Maiden name Lydia Bittinger

15. Birthplace Grantsville, Md.

16. Informant Shannon Evans

Address 196 Railroad St - Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 15, 1940. (month) (day) (year)

Cemetery or crematory Eckhart, Md.

Location Eckhart Md.

18. Funeral director Jacob Hofer.

Address Frostburg, Md.

19. Aug. 13, 1940 (Date rec'd by registrar) Nancy H. Rae Registrar

Dr. Diehl.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1940, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 12 1940, to Aug. 12 1940, and that I last saw her alive on Aug. 12 1940.

Immediate cause of death	DURATION
Pulmonary embolism during delivery & mal-	
Due to formed foetus (stillborn)	12 hrs.
Due to [Fault - term]	
Other conditions Mal-formed foetus (stillborn)	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. Diehl, M.D. M. D. or other

Address Frostburg, Md Date signed 8/13/40.

RECEIVED
SEP 4 1940
BUREAU OF S

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

08220

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
714 East Oldtown Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 714 East Oldtown Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: George W Ferguson

3. (b) Social Security Number: None

4. Sex	5. Color or race	b.(a) Single, married, widowed, or divorced
M	White	Widowed

6.(b) Name of husband or wife: Mollie Boyster
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 22 1860

8. AGE:

Years	Months	Days	If less than one day
80	6	16	hrs. min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)
10. Usual occupation: Retired Bookkeeper for
11. Industry or business: B & O Rail Road

FATHER
12. Name: James Ferguson
13. Birthplace: Md.

MOTHER
14. Maiden name: Rose Peterman
15. Birthplace: Md

18. Informant: Mrs Hazel Shartle
Address: Cumberland, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 8 8 40
(month) (day) (year)
Cemetery or crematory: Trinity Lutheran Cem
Location: Cumberland, Md.

18. Funeral director: Louis Steiner Sons
Address: Cumberland, Md.

19. Aug 8 1940
(Date rec'd by registrar)
J. P. Franklin, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 6 1940, at 8:10 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 31 1940, to Aug 6 1940
and that I last saw him alive on Aug 4 1940

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James E. McLean M.D.
M. D. or other
Address: 122 Baltimore St. Date signed: 8-7-40

RECEIVED
SEP 6 1940
U. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-B)

08221

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 3 mos. 26 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Mt. Savage Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME Fiorita, Rosella

3. (b) Social Security Number 212-18-1747

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband ~~or wife~~ Raymond Fiorita

6(c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) Aug 20, 1912

8. AGE: Years 28 Months 0 Days 11 If less than one day ___ hrs. ___ min.

9. Birthplace Barrellsville, Md.
(Town, county, and state)

10. Usual occupation Housekeeper - Seamstress

11. Industry or business At Home - W.P.A.

FATHER
12. Name Jacob Bridges
13. Birthplace Beans Cove, Pa.

MOTHER
14. Maiden name Fannie Blucker
15. Birthplace Sallisbury, Pa.

16. Informant Raymond Fiorita

Address Mt. Savage

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 3 1940 (month) (day) (year)

Cemetery or crematory St Peters & Paul

Location Cumberland, Md

18. Funeral director Jacob Hofer

Address Cumberland Md

19. Sept. 2 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31, 1940, at 1:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4 1940, to Aug 31 1940, and that I last saw her alive on August 31, 1940.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	?
Due to Tuberculosis peritonitis	5 month
Endocarditis	2 month
Due to	
Other conditions Salpingitis	?

(Include pregnancy within 3 months of death)

Major findings:
Of operations Intercolar Cysts

Of autopsy No

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T. Bailey Hunter M. D. ~~or other~~

Address Cumberland Md Date signed 9/2/40

Dr Hunter

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

08222

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 35 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Williams Road, Route #2
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: CARRIE FLEEK

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James D. Fleek

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): May 20, 1904

8. AGE: Years	Months	Days	If less than one day
36	4	5	..... hrs. ..... min.

9. Birthplace: W. Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Jacob M. Lewis
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Elizabeth Howderschell
15. Birthplace: W. Va.

16. Informant: David Lewis

Address: R.D.#2 Williams Rd. Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 28, 1940 (month) (day) (year)

Cemetery or crematory: Mt. Herman Cem.

Location: Near Cumberland

18. Funeral director: J. C. Wolford

Address: Cumberland, Md.

19. Aug. 28, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 25, 1940, at 3:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 25 1940, to August 25 1940 and that I last saw her alive on August 25 1940

Immediate cause of death: Cerebral Hemorrhage. — DURATION: 1 hour

Due to: Hypertension cause unknown. — 1 year.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D.
M. D. or other

Address: Cumberland, Md. Date signed: 8/25/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

08223

Reg. Dist. No. 4

1. PLACE OF DEATH

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 yrs.

Hospital, Institution, or street address where death occurred: 309 South St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 309 South St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harriett Ellen Flora

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Jasper N. Flora

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 22 1889

8. AGE:

Years	Months	Days	If less than one day
50	11	28	..... hrs. ..... min.

9. Birthplace: W. Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER

12. Name: Adam Kaylor

13. Birthplace: W. Va.

MOTHER

14. Maiden name: Anna Sergent

15. Birthplace: W. Va.

16. Informant: Jasper N. Flora

Address: Cumberland

17. Burial, cremation, or removal. Which? Burial Date thereof: Aug 22 40 (month) (day) (year)

Cemetery or crematory: Hillcrest Cem.

Location: Cumberland Md.

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. Aug 21 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 20 1940, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 20 1939 to Aug 20 1940 and that I last saw h.. alive on Aug 20 1940

	DURATION
Immediate cause of death: Diabetes	about 8 mo.
Due to: Malnutrition	1 yr
Due to: Anemia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: 133 Va Date signed: 8/21/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

08224

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 57 yrs.

Hospital, Institution, or street address where death occurred: 331 Bedford St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 331 Bedford St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Edgar L. Flury

3. (b) Social Security Number None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 13 1883

8. AGE: Years 57 Months 4 Days 13 If less than one day ..... hrs. ..... min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Motion Picture operator

11. Industry or business

FATHER
12. Name: Edgar L. Flury
13. Birthplace: Md.

MOTHER
14. Maiden name: Clara Miller
15. Birthplace: Md.

16. Informant: Liddia Flury

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 29 40 (month) (day) (year)

Cemetery or crematory: St. Lukes Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. Aug. 29 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26 1940, at 4:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 24 1940, to Aug 26 1940 and that I last saw him alive on Aug 24 1940

Immediate cause of death: Chronic myocarditis

Due to: Hypertension

Due to:

Other conditions

(Include pregnancy within 8 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. B. Barrow MD. M. D. or other

Address: 122 Bedford St Date signed: 8/29/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(170-C)

CERTIFICATE OF DEATH

08225

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Dist.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany.

City or town Cumberland. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Becker Hotel, Long Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William Rowe Foard.

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	married

6 (b) Name of husband or wife Maud C. Foard.

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 24 1882

8. AGE: Years	Months	Days	If less than one day
58	11	20	hrs. min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Doctor

11. Industry or business

FATHER 12. Name Alfred D Foard

13. Birthplace Md.

MOTHER 14. Maiden name Adelia Rowe.

15. Birthplace Md.

16. Informant Mrs M C Foard.

Address Cumberland Md

17. Burial Date thereof Aug 7 40

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenmount Cemetery

Location Cumberland Md

18. Funeral director Louis Klein Inc

Address Cumberland Md

19. Aug. 7, 1940 J. L. Franklin, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4th., 1940, at 6P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____, 19____, to ____, 19____, and that I last saw h____ alive on ____, 19____.

	DURATION
Immediate cause of death Fractured skull, deep, punctured wound of epigastrium	18 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Aug. 4th., 40

Where did injury occur? Cumberland, Allegany, Maryland.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) street intersection

Means of injury Struck by auto while crossing street Injured at work? no

23. SIGNATURE Richard H. Bowen M.D.

M. D. or other

Address Cumberland, Maryland. Date signed 8/5/40

Deputy Medical Examiner - Allegany Co.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
SEP 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (60-a)

08226

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Allegany

City or town: Frostburg, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Spires Hospital

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town: Frostburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.:

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME Infant Gonglaw

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced:

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 13th, 1940

8. AGE: Years: 8 hrs. Months: Days: If less than one day: hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER 12. Name: Ed. J. Gonglaw

13. Birthplace: W. Va.

MOTHER 14. Maiden name: Eleanor Evans

15. Birthplace: Frostburg, Md.

16. Informant: Ed. J. Gonglaw

Address: 156 Bonaparte St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 14 1940 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: Daniel Dafler

Address: Frostburg, Md.

19. Aug 13 1940 (Date rec'd by registrar) Nancy V. Rae Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 13 1940, at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 13 1940, to Aug 13 1940, and that I last saw her alive on Aug. 13 1940.

Immediate cause of death: Intra-cranial hemorrhage.

DURATION: 8 hrs.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. C. Diehl, M.D. M. D. or other

Address: Frostburg, Md. Date signed: 8/13/40

RECEIVED
SEP 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

08227

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): Births.

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Valley Rd. Route # 3
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Infant Gentry

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced:

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 13, 1940

8. AGE: Years | Months | Days | If less than one day: 2 hrs. 30 min.

9. Birthplace: Cumberland, Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: Frederick Allen Gentry

FATHER 13. Birthplace: Cumberland, Maryland

MOTHER 14. Maiden name: Nancy Louise Marker

MOTHER 15. Birthplace: Thomas, West Virginia

16. Informant: Mrs Nancy Gentry

Address: Route 3 Valley Road City

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 14/40 (month) (day) (year)

Cemetery or crematory: Zion Memorial Cem

Location: Bedford Road City

18. Funeral director: William H. Right

Address: Cumberland Md

19. Aug. 14 (Date rec'd by registrar) 19 40 J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 13, 1940, at 10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw h____ alive on ____ 19____.

	DURATION
Immediate cause of death: Premature	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 133 Van Date signed: 8/13/40

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

08228

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Star Route - Oakland (If outside city or town limits, write RURAL and give nearest town)

Street No.: Near Oakland, Md. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Baby Girl Glass

3.(b) Social Security Number: None

4. Sex	5. Color or race	b.(a) Single, married, widowed, or divorced
Female	W	—

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): August 4, 1940

8. AGE: Years: Premature | Months | Days | If less than one day: hrs. min.

9. Birthplace: Cumberland, Allegany, Md. (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: Robert Glass

13. Birthplace: Oakland, Maryland

MOTHER — 14. Maiden name: Oline Friend

15. Birthplace: Oakland, Md

16. Informant: Allegany Hospital

Address: Cumberland, Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Aug. 14, 1940 (month) (day) (year)

Cemetery or crematory: Helis Funeral Home

Location: Cumberland, Md

18. Funeral director: Jacob Haller

Address: Cumberland, Md

19. Aug. 14 1940 J. P. Franklin M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 4 1940, at 7.15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw ..... alive on ..... 19.....

Immediate cause of death	DURATION
PREMATURE BIRTH	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. B. Barnes M.D. (M. D. or other)

Address: 122 Bedford St Date signed: 8/5/40

RECEIVED
SEP 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

08230

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 yrs

Hospital, Institution, or street address where death occurred: 78 W Loo St

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 78 W Loo St

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME Hannah A. Dasting

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Henry Dasting

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 10 - 1859

8. AGE: Years 80 | Months 11 | Days 18 | If less than one day ..... hrs. ..... min.

9. Birthplace: Conrad Village (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Henry Schell

13. Birthplace: Germany

MOTHER 14. Maiden name: Elizabeth Roeder

15. Birthplace: Germany

16. Informant: Elizabeth Dasting

Address: 78 Loo St Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 31 1940 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg Md

18. Funeral director: Jacob Dasting

Address: Frostburg Md

19. Aug. 31, 1940 (Date rec'd by registrar) Nancy N. Rae Asst. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 28 1940, at 10:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22 1940, to Aug 28 1940

and that I last saw her alive on Aug 28 1940

Immediate cause of death: Uremia Edema

DURATION: Several Years

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W D McLane M.D. M. D. or other

Address: Frostburg Md Date signed: Aug 29/40

RECEIVED
SEP 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08229

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Frostburg, Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 129 Center St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 70 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 129 Center St

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Philip Hartig sr.

3. (b) Social Security Number 218-07-7415

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Elizabeth

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Mar 30 1870

8. AGE: Years: 70 Months: 4 Days: 10 If less than one day ____ hrs. ____ min.

9. Birthplace: Frostburg Md (Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business: Savings Bank

FATHER 12. Name: Philip Hartig

13. Birthplace: Germany

MOTHER 14. Maiden name: Martha E Miller

15. Birthplace: Germany

16. Informant: Philip Hartig

Address: 133 Maple St

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8 (month) 13 (day) 40 (year)

Cemetery or crematory: Allegany Co.

Location: Frostburg, Md

18. Funeral director: Jacob Wade

Address: Frostburg Md

19. Aug 12 1940 (Date rec'd by registrar) Nancy H. Roe Registrar

Dept.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 10 1940, at 1330 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 1938, to Aug 10 1940, and that I last saw him alive on Aug 1 1940

Immediate cause of death: Angina Pectoris — DURATION: 3 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Ot operations

Ot autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm McLane M.D. M. D. or other

Address Frostburg Md Date signed 8-12-40

RECEIVED
SEP 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08231

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany Hospital

City or town Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No. 2
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 221 Water Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Haislip

3. (b) Social Security Number None

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 28, 1940

8. AGE: Years Months Days Stillborn If less than one day hrs. min.

9. Birthplace Allegany Hospital, Cumberland, Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Robert Haislip
13. Birthplace Grafton, West Virginia

MOTHER
14. Maiden name Oasie, Deremer
15. Birthplace Cumberland Maryland

16. Informant Oasie Deremer Haislip

Address 221 Water Street

17. Cremation
(Burial, cremation, or removal. Which?)

Date thereof Aug. 31, 1940
(month) (day) (year)

Cemetery or crematory Lempereur Funeral Home

Location Cumberland, Md.

18. Funeral director V. L. Lempereur

Address Cumberland Md

19. Aug. 31 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1940, at 28 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,

and that I last saw h elive on 19

Immediate cause of death 3 month gestation

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T. Bailey Hunter
M. D. or other

Address Cumberland Md Date signed 8/24/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-7)

CERTIFICATE OF DEATH

08232

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Allegany Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 502 Cumberland St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Helen W Hedges

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Samuel Hedges
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): unknown.

8. AGE: Years: 86 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Cumberland Md
(Town, county, and state)

10. Usual occupation: Home.

11. Industry or business

FATHER
12. Name: Samuel Truman
13. Birthplace: Cumberland Md

MOTHER
14. Maiden name: Jane Loatts
15. Birthplace: Md

16. Informant: Frank Truman.
Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 13, 40 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetary
Location: Cumberland Md.

18. Funeral director: Louis Stein Sons
Address: Cumberland Md.

19. Aug 13 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-12-40 19..... at 4 20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-26-38 19..... to 8-12-40 19.....
and that I last saw h.r. alive on 8-11-40 19.....

Immediate cause of death	DURATION
Carcinoma rectum followed by Carcinomatosis	5 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. Alfred Van Arna
M. D. or other
Address: Cumberland, Md. Date signed: 8-12-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1940
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (169)

CERTIFICATE OF DEATH

08233

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany.

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 4 miles East of Cumberland. Md on

Stay ~~in hospital or inst. (yrs., or mos., or days)~~ B & O Rail Road

~~Stay in this community (yrs., or mos., or days)~~

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 430 Virginia ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Vickroy A Hillearys

3. (b) Social Security Number: 214-07-0041

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	married

6 (b) Name of husband or wife: Freda D Finkelday

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Nov 30 1900

8. AGE: Years	Months	Days	If less than one day
34	8	7	____ hrs. ____ min.

9. Birthplace: Cumberland md (Town, county, and state)

10. Usual occupation: Laborer.

11. Industry or business: B & O Rail Road

FATHER 12. Name: Harry C Hillearys

FATHER 13. Birthplace: West Va.

MOTHER 14. Maiden name: Ellen Kelley.

MOTHER 15. Birthplace: West Va.

16. Informant: Mrs F D Hillearys

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 8, 40 (month) (day) (year)

Cemetery or crematory: Hillcrest Cem.

Location: Cumberland, Md

18. Funeral director: Louis Shimberg

Address: Cumberland Md

19. Aug. 7 1940 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION about 9.30

20. DATE OF DEATH: August 6th., 1940, at A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

	DURATION
Immediate cause of death: Decapitation.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy: none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 8/6/40

Where did injury occur? about 4 miles east of Cumberland, (City or town) Allegany, (County) Maryland. (State)

Injured at home, farm, industry, public place (where?): B and O R.R. track

Means of injury: struck by train Injured at work? no

23. SIGNATURE: Louis H. Brown, M.D. (M. D. or other)

Address: Cumberland, Maryland. Date signed: 8/6/40

Deputy Medical Examiner - Allegany Co!

RECEIVED
AUG 17 1940
BUREAU V.S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-E)

CERTIFICATE OF DEATH

08234

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: LaVale
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: LaVale Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Near Cumberland
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Irving W. Holmes

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Maryland Walker
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 19, 1865

8. AGE:

Years	Months	Days	If less than one day
75	3	6	hrs. min.

9. Birthplace: Pittsburgh, Penna.
(Town, county, and state)

10. Usual occupation: Retired Foundry Man

11. Industry or business

FATHER
12. Name: Josiah Holmes
13. Birthplace: England

MOTHER
14. Maiden name: Francis Lee
15. Birthplace: England

16. Informant: Mrs. Maryland Holmes
Address: LaVale, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 28, 1940 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland

18. Funeral director: J. C. Wolford
Address: Cumberland, Md.

19. Aug. 28, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 25, 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 40, to Aug 25 19 40, and that I last saw h in alive on Aug 25 19 40.

Immediate cause of death	DURATION
Heart Failure	[illegible]
Due to Chron Endo & Myocarditis	2y
Due to Chron Myocarditis	2y
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: 41 Green St Cumberland Date signed: Aug 27 40

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53a

CERTIFICATE OF DEATH

08235

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 39 yrs.

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 705 Springdale St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Robert Charles Humbird

3. (b) Social Security Number 705-05-4634

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Helen Barger

6.(c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) Feb 11 1901

8. AGE:

Years	Months	Days	If less than one day
39	5	29	... hrs. ... min.

9. Birthplace Cumberland Md (Town, county, and state)

10. Usual occupation Welder.

11. Industry or business B & O Ry.

FATHER

12. Name John H Humbird

13. Birthplace Md.

MOTHER

14. Maiden name Sarah Bell

15. Birthplace Md

16. Informant Mrs Helen Humbird

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 13 40 (month) (day) (year)

Cemetery or crematory Rose Hill Mem.

Location Cumberland.

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Aug 12 19 40 J. P. Franklin, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 19 40, at 9 40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 8 19 40, to Aug 10 19 40

and that I last saw h[illegible] alive on Aug 10 19 40

Immediate cause of death	DURATION
Cerebral Apoplexy	2 dy.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE W. B. Owens M. D. or other

Address 133 Va Date signed 8/12/40

RECEIVED
AUG 14 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

08236

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(117-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hosp.

How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State WEST VIRGINIA County MINERAL

City or town PIEDMONT
(If outside city or town limits, write RURAL and give nearest town)

Street No. 92 ASHFIELD STREET
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME MR. AUBREY N. HUTH

3. (b) Social Security Number 236-12-1817

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) AUGUST 13, 1889

8. AGE: Years	Months	Days	If less than one day
51	0	8	..... hrs. ..... min.

9. Birthplace WEST VIRGINIA (Town, county, and state)

10. Usual occupation SEC'Y AND BOOKKEEPER

11. Industry or business

FATHER
12. Name CHARLES F. HUTH (DECEASED)
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden name EMMA COOK
15. Birthplace MARYLAND

16. Informant Mrs. Charles Huth
Address Piedmont. W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 24 1940 (month) (day) (year)

Cemetery or crematory Philos Cemetery

Location Westernport, Md.

18. Funeral director David S. Boal
Address Westernport, Md.

19. Aug 21, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION 8:30 A.M

20. DATE OF DEATH AUGUST 21 1940, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 20 1940, to Aug 21 1940 and that I last saw him alive on Aug 20 1940

Immediate cause of death Perforated gastric ulcer (operated) — DURATION 2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Perforated gastric ulcer (lesser curvature) Date of op. Aug 20, 1940

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. M. Wilson M.D. M. D. or other

Address Cumberland Md. Date signed Aug 21, 1940

DR. F. WILSON & W. F. WILLIAMS

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

08237

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(107)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred: 328 N. Mechanic St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany.

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 328 N. Mechanic St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ernst Frederick Jahn

3. (b) Social Security Number None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Elizabeth Straub

6.(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.): Sept 22. 1861

8. AGE: Years 78 | Months 10 | Days 10 | If less than one day ..... hrs. ..... min.

9. Birthplace Leipzig, Germany.
(Town, county and state)

10. Usual occupation Soap Manufacturer

11. Industry or business Soap Business.

FATHER
12. Name Jahn
13. Birthplace Unknown

MOTHER
14. Maiden name Wilhimina
15. Birthplace Unknown

16. Informant Mrs Paul Koellser
Address 330 N. Mechanic St.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Aug 6, 1940
(month) (day) (year)

Cemetery or crematory St. Lukes

Location Cumberland Md.

18. Funeral director Jacob Hofer
Address Cumberland Md.

19. Aug 6, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

Dr Snyder

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 3 1940, at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 3, 1940, to Aug 3, 1940 and that I last saw him alive on Aug. 3 1940

Immediate cause of death: Pneumonia Bronchial with Pulmonary Oedema

DURATION: 10 Yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. F. O. Snyder
M. D. or other

Address Cumberland Md. Date signed 8-6-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

RECEIVED
SEP. 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08238

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
272 Main
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 272 Main
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME "Baby" Jones

3.(b) Social Security Number

4. Sex: Female | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 11, 1940

8. AGE: Years | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Westernport Allegany - Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: not known

13. Birthplace

MOTHER 14. Maiden name: Glendine Jones

15. Birthplace: Frankville, Md.

16. Informant: Mrs. J. R. Jones

Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/1940 (month) (day) (year)

Cemetery or crematory: Philips

Location: Westernport, Md.

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Md.

19. Aug. 12 1940 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 11, 1940, at 9:40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11, 1940, to August 11, 1940, and that I last saw h.e.r. alive on ..... 19..... dead on arrival

	DURATION
Immediate cause of death: Suffocation	
Due to: Breech Delivery	15 mins
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Jas. H. Wolverton Jr. M.D. (M. D. or other)

Address: Piedmont W. Va. Date signed: 8/12/1940

RECEIVED
SEP 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08239

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Miners hospital
Stay in hospital or inst. (yrs., or mos., or days): 12 hours
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Eckhart Mines Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Charles Kocola
3. (b) Social Security Number: None

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Jan. 15 - 1871

8. AGE: Years 69 Months 7 Days 9 If less than one day hrs. min.

9. Birthplace: Austria (Town, county, and state)
10. Usual occupation: Retired Miner
11. Industry or business: Coal mines

FATHER
12. Name: Unk.
13. Birthplace: Unk.

MOTHER
14. Maiden name: Unk.
15. Birthplace: Unk.

16. Informant: George Korige
Address: Eckhart Mines Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 26-1940 (month) (day) (year)
Cemetery or crematory: St. Michael's Cemetery
Location: Frostburg, Md.

18. Funeral director: J. J. Durst
Address: Frostburg, Md.

19. Aug. 26 1940 (Date rec'd by registrar) Nancy H. Rae Dept. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 24 1940, at 1:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 23 1940, to Aug 24 1940, and that I last saw him alive on Aug 23 1940.

Immediate cause of death: Lobar Pneumonia
DURATION: about 4 Day
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. D. McLane Jr. M.D. M. D. or other
Address: Frostburg Md. Date signed: Aug 26 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157) CP

08240

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD. MEMORIAL HOSPITAL
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos. 15 days
Hospital, Institution or street address where death occurred: Memorial Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VIRGINIA County Morgan
City or town PAW PAW
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME LEACH, BABY GIRL

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE (INFANT)

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) MAY 31, 1940 8.(c) If alive, give age ..... years

8. AGE: Years | Months 2 | Days 16 | If less than one day ..... hrs. ..... min.

9. Birthplace Paw Paw W. Va. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name GEORGE LEACH
13. Birthplace WEST VIRGINIA

MOTHER 14. Maiden name MAY FLORA
15. Birthplace WEST VIRGINIA

16. Informant GEORGE LEACH
Address PAW PAW WEST VIRGINIA

17. Removal (Burial, cremation, or removal, Which?) Date thereof Aug. 19 1940 (month) (day) (year)
Cemetery or crematory Paw Paw Cem.
Location Paw Paw, W. Va.

18. Funeral director W. D. Parks
Address Paw Paw W. Va.

19. Aug. 19 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. ELIASON

MEDICAL CERTIFICATION 6;50 A.M.

20. DATE OF DEATH AUGUST 17, 1940 19..... at ..... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE H. W. Eliason M.D. M. D. or other
Address 26 Prospect Cumberland Date signed 8/17/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

08241

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Eckhart, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Eckhart Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Samuel J. Lewis

3. (b) Social Security Number: 214-01-6653

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B (b) Name of husband or wife: Annie Lewis

6(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Feb 9 — 1875

8. AGE:

Years	Months	Days	If less than one day
65	5	29	hrs. min.

9. Birthplace: Eckhart - Alley - Md.

(Town, county, and state)

10. Usual occupation: coal miner

11. Industry or business:

FATHER

12. Name: Owen Lewis

13. Birthplace: Wales

MOTHER

14. Maiden name: Elizabeth Porter

15. Birthplace: Md.

18. Informant: Ruben Lewis

Address: Eckhart

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 10 1940 (month) (day) (year)

Cemetery or crematory: Eckhart

Location: Eckhart, Md.

18. Funeral director: J. F. Durst

Address: Frostburg, Md.

19. Aug 10 1940 (Date rec'd by registrar) Nancy A. Rae Registrar Dept.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 8 1940, at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27 1940, to Aug 8 1940, and that I last saw him alive on Aug 8 1940.

Immediate cause of death	DURATION
Coronary occlusion	
due to Myocarditis	
Due to Congestive Heart failure	
Bronchial asthma	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A. M. Earl Jr. M.D. or other

Address: Frostburg, Md. Date signed: 8-8-40

RECEIVED
SEP 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (121)

CERTIFICATE OF DEATH

08242

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 14 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town ACCIDENT

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME EFFIE LISTON (MRS.)

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife HARRY LISTON

6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) AUGUST 5, 1896

8. AGE: Years	Months	Days	If less than one day
44	0	20	hrs. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name FREDERICK HOCKMAN

13. Birthplace MARYLAND

MOTHER 14. Maiden name ELIZABETH RINGER

15. Birthplace PENNSYLVANIA

16. Informant HARRY LISTON

Address ACCIDENT, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 27, 1940 (month) (day) (year)

Cemetery or crematory Cemetery

Location Accident Md.

18. Funeral director Collins Funeral Home

Address Terra Alta W. Va.

19. Aug 26, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH AUGUST 25, 1940, at 9:50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 11 1940, to Aug 25 1940

and that I last saw h. alive on Aug 24 1940

Immediate cause of death	DURATION
Pulmonary Embolism	
Due to	
Due to Appendicitis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Gangrenous appendix

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. G. Mockler M. D. or other

Address Cumberland Date signed Aug 26-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (120-a)

08243

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 8 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Ohio County: Butler

City or town: Dayton
(If outside city or town limits, write RURAL and give nearest town)

Street No. 19 Stockton ave
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME Robert Holle Luechaver LUECHAVER

3. (b) Social Security Number None

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 2 1931

8. AGE: Years 9 | Months 8 | Days 13 | If less than one day ..... hrs. ..... min.

9. Birthplace: Dayton Ohio
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business

FATHER
12. Name: Holle Luechaver
13. Birthplace: Ohio

MOTHER
14. Maiden name: Edna Block
15. Birthplace: Ohio

16. Informant: Holle Luechaver
Address: 19 Stockton St Dayton Ohio

17. Removal (Burial, cremation, or removal, Which?) Date thereof: Aug 17 1940 (month) (day) (year)

Cemetery or crematory: Hamilton Cem

Location: Hamilton Ohio

18. Funeral director: Lewis Shim Inc
Address: Cumberland Md

19. Aug 15 1940 (Date rec'd by registrar) J. L. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 15 1940, at 4:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 14 1940, to Aug 15 1940 and that I last saw him alive on Aug 15 1940

Immediate cause of death: Acute Gastro Enteritis — DURATION: 3 days

Due to: Drinking bad water and eating infected food

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: F. Alan G. Morrison M.D. M. D. or other

Address: 41 Green St Cumberland Md Date signed: Aug 15 40

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-9)

CERTIFICATE OF DEATH

08244

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.

(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yrs.

Hospital, Institution, or street address where death occurred:

901 Virginia Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany.

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Sireet No. 901 Virginia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Martha Christina Moreland Martin

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Chas. J. Martin

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): Nov 9, 1879

8. AGE:

Years	Months	Days	If less than one day
60	8	25	...hrs. ...min.

9. Birthplace: Hampshire County W. Va.

(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: At Home

FATHER

12. Name: James Moreland

13. Birthplace: Hampshire County, W. Va

MOTHER

14. Maiden name: Mary Malcolm

15. Birthplace: Not Known.

16. Informant: Chas. J. Martin

Address: 901 Va. Ave - Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 7 1940 (month) (day) (year)

Cemetery or crematory: Wesley Chapel

Locafion: Points W. Va.

18. Funeral director: Jacob Hafer

Address: Cumberland Md.

19. Aug 7 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4, 1940, at 7:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1940, to June 4, 1940 and that I last saw h... alive on June 2, 1940

	DURATION
Immediate cause of death: Generalized Arteriosclerosis	1 yr
Due to: Chronic nephritis	
Due to: Uraemia	Jan. 1940
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline tbe canse tn which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Chas. J. Martin M. D. or other

Address: Cumberland, Md. Date signed: Aug. 6, 1940

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08245

(93-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Home - 546 N. Centre St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 546 N. Center St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Aaron May

3. (b) Social Security Number None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Mary K Straub

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 1 1870

8. AGE: Years 80 | Months 7 | Days 6 | If less than one day ..... hrs. ..... min.

9. Birthplace: Penna. (Town, county, and state)

10. Usual occupation: Contractor

11. Industry or business: Own

FATHER

12. Name: Simon May

13. Birthplace: Penna.

MOTHER

14. Maiden name: Emmaline McKewn

15. Birthplace: Penna.

16. Informant: Clement May

Address: La Vale Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-10-40 (month) (day) (year)

Cemetery or crematory: St Peter + Paul

Location: Cumberland Md.

18. Funeral director: V. L. Lempereur

Address: 202 Green St.

19. Aug. 10 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 7, 1940, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 7, 1940, to Aug 7, 1940 and that I last saw him alive on about 6 mo. ago. 19

Immediate cause of death	DURATION
acute myocarditis	Sudden
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address [illegible] Md. Date signed 8-10-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 6 1940
[illegible] V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-L)

08246

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs.

Hospital, institution, or street address where death occurred: 644 Lincoln St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 644 Lincoln St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Nora Conner Minnicks

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Divorced

6.(b) Name of husband or wife: Peter Minnicks

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 18 1879

8. AGE: Years: 69 Months: 7 Days: 24 If less than one day ..... hrs. ..... min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Seamstress

11. Industry or business: Retired 3 yrs.

FATHER
12. Name: James Conners
13. Birthplace: Md.

MOTHER
14. Maiden name: Viola Mansell
15. Birthplace: Md.

16. Informant: Mrs Emory H Layman

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 14 '40 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland, Md.

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. Aug 13 1940 (Date rec'd by registrar) J. T. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 12 1940 at 5 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw her alive on Aug 11 1940

Immediate cause of death: Chronic Myocarditis and Myocardial degeneration

DURATION: 18 mos

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R. W. Trevaskis M.D. M. D. or other

Address: Cumberland, Md Date signed: Aug 12-'40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (125b)

08247

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 6 days

Stay in this community (yrs., or mos., or days) 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett

City or town Rural Near-Mt. Lake Park Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 4 Mi. S. Mt. Lake Park

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ----

3. (a) FULL NAME Shirley Ann Moreland

3. (b) Social Security Number -----

4. Sex: Female

5. Color or race: white

6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 21 - 1940

8. AGE: Years + Months 1 Days 27 If less than one day ____ hrs. ____ min.

9. Birthplace Mt Lake Park - Garrett Co Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Arthur Moreland

13. Birthplace Gorman; Garrett Co., Md.

MOTHER 14. Maiden name Dorothy Louise Kiser

15. Birthplace Latrobe, Penna.

16. Informant Arthur Moreland

Address Mt. Lake Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 20, 1940 (month) (day) (year)

Cemetery or crematory Oakland Cemetery

Location Oakland, Maryland.

18. Funeral director Herbert C. Leighton

Address Oakland, Md.

19. Aug. 27 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1940, at 7 19 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 12 1940, to Aug 18 1940, and that I last saw her alive on Aug 18 1940.

Immediate cause of death: Acute Hepatitis — DURATION 3 wks

Due to Icterus Neonatorum — 4 wks

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE C L Owens M D M. D. or other

Address Cumberland Md Date signed Aug 18 1940

Funeral Director on vacation. Circumstances explained satisfactorily.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1940
BUREAU V. S.

08248

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(46-7)

Reg. Dist. No. 42

1. PLACE OF DEATH:

County: Allegany

City or town: Rural near Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 years

Hospital, institution, or street address where death occurred: Rural near Cumberland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Rural near Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Between Cumberland & Flintstone
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Charles Wesley Morgan

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Emma Jane Robosson

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Sept 15, 1877

8. AGE: Years: 62 Months: 10 Days: 19 If less than one day: hrs. min.

9. Birthplace: Green Ridge, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation: Saw Mill Operator

11. Industry or business: Lumber

FATHER
12. Name: Samuel C. Morgan
13. Birthplace: Green Ridge, Md.

MOTHER
14. Maiden name: Mary Robison
15. Birthplace: Paw Paw, W. Va

16. Informant: Mrs. Chas. Morgan

Address: Flintstone R.F.D. Route 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 7, 1940 (month) (day) (year)

Cemetery or crematory: Prosperity Methodist

Location: Pleasant Valley, Md.

18. Funeral director: Jacob Hafer

Address: Cumberland, Md.

19. Aug 7, 1940 (Date rec'd by registrar) J. P. Franklin Registrar

Royce Hodges

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 4 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 27 1939, to Aug 4 1940 and that I last saw him alive on July 3 1940

Immediate cause of death: Carcinoma of Liver (Primary)

Due to: ?

Due to:

Other conditions: —

(Include pregnancy within 3 months of death)

DURATION

Major findings of operation: Liver studded I nodules. Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: — Injured at work? —

23. SIGNATURE: W. Royce Hodges M. D. or other

Address: Cumberland, Md. Date signed: 8/6/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 4 1940
BUREAU V. S.

08249

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 hours

Hospital, institution, or street address where death occurred: The Reeves Clinic

How long in hospital or institution? 3 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State ..... County .....

City or town: Swanton
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME: Infant Otto

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 2, 1940

8. AGE: Years | Months | Days | If less than one day: 3 hrs. ..... min.

9. Birthplace: Westernport, Allegany Co., Maryland
(Town, county, and state)

10. Usual occupation .....

11. Industry or business

FATHER
12. Name: William Otto
13. Birthplace: Swanton, Md.

MOTHER
14. Maiden name: Lena Helen Groves
15. Birthplace: Aarons Run, Md.

16. Informant: William L. Otto
Address: Swanton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 4, 1940 (month) (day) (year)

Cemetery or crematory: Swanton

Location: Swanton, Md

18. Funeral director: William L. Otto
Address: Swanton, Md

19. Aug. 3 1940 (Date rec'd by registrar) A. Gaymbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 2 1940 10 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 2 1940, to Aug 2 1940 and that I last saw him alive on Aug 2 1940

Immediate cause of death: Prematurity -

Due to: Nephritis Hypertension of mother -

Due to .....

Other conditions .....
(Include pregnancy within 3 months of death)

DURATION: 5 6 6 mo.

Major findings of operations .....
Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R W Reeves, M.D. M. D. or other

Address: Westernport Md Date signed: 8/3/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

08250

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:
County: Allegany
City or town: Westernport, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, Institution, or street address where death occurred:
The Reeves Clinic
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME
Otto

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 2, 1940

8. AGE: Years	Months	Days	If less than one day
		3	hrs. min.

8. Birthplace: Westernport, Allegany Co., Maryland
(Town, county, and state)

10. Usual occupation:
11. Industry or business

FATHER
12. Name: William Otis Otto
13. Birthplace: Swanton, Md.

MOTHER
14. Maiden name: Lena Helen Groves
15. Birthplace: Aarons Rum, Md.

16. Informant: William L. Otto
Address: Swanton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 5 1940 (month) (day) (year)
Cemetery or crematory: Swanton
Location: Swanton, Md
18. Funeral director: William L. Otto
Address: Swanton, Md

19. Aug. 5 1940 (Date rec'd by registrar) O. J. Baynbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5, 1940, at 8:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 2 1940, to Aug 5 1940 and that I last saw him alive on 8-5-40, 1940

Immediate cause of death	DURATION
Prematurity	5-6
Due to Nephritis Hypertension	
Due to Toxaemia of Pregnancy	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: L. O. Reeves, M. D. (M. D. or other)
Address: Westernport Md. Date signed: 8-5-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-B

CERTIFICATE OF DEATH

08251

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 4 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County GARRETT
City or town KITZMILLER
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME WILLIAM PEW, MR.

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife EDITH RUBLE PEW
6.(c) If alive, give age 29 years
7. Birth date of deceased (mo., day, yr.) APRIL 14 1899

8. AGE: Years	Months	Days	If less than one day
41	3	23	hrs. min.

9. Birthplace PENNSYLVANIA (Town, county, and state)
10. Usual occupation UNEMPLOYED
11. Industry or business
FATHER 12. Name WILLIAM NESBIT (DECEASED)
13. Birthplace PA. GEORGE B. PEW (FOSTER FATHER)
MOTHER 14. Maiden name ALICE PHENNIECIE
15. Birthplace PENNSYLVANIA
16. Informant Memorial Hospital
Address Cumberland Md
17. Removal (Burial, cremation, or removal. Which?) Date thereof aug 10/40 (month) (day) (year)
Cemetery or crematory I.O.O.F Cemetery
Location Elk Garden W Va
18. Funeral director C. F. Sharpless
Address Blaine, W Va
19. Aug 8 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 7 1940 at 6:45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-3- 1940 to 8-7- 1940 and that I last saw him alive on 8-6- 1940

Immediate cause of death	DURATION
Obstruction of pyloroma and duodenum.	
Due to Carcinoma of stomach cont	?
Due to Carcinomatosis of abdominal viscera	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations None
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. J. Williams M. D. or other
Address Cumberland Date signed 8-7-40

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

CERTIFICATE OF DEATH

08252

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL Hospital

Stay in hospital or inst. (yrs., or mos., or days) 20 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Md. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 115 So Smallwood St.

(If rural give LOCATION)

2(e) IF VETERAN, NAME WAR

3. (a) FULL NAME Paul Pillon

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (c) Single, married, widowed, or divorced
MALE	W	(Separated.)

6 (b) Name of husband or wife Rosie Wilcox

6(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) MARCH 12 1862

8. AGE:

Years	Months	Days	If less than one day
78	4	28	____ hrs. ____ min.

9. Birthplace FRANCE (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Louis Pillon

13. Birthplace France.

MOTHER 14. Maiden name Rosalie Bisson

15. Birthplace France.

16. Informant Mrs. N. Osborne.

Address 115 So Smallwood St.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 8-11-40 (month) (day) (year)

Cemetery or crematory St Mt. HERMAN

Location Wms Road.

18. Funeral director V. J. Lempereur

Address 202 Green St

19 Aug. 10 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8 1940, at 7.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 2 1940 to Aug. 8 1940 and that I last saw h L M alive on Aug. 8 1940.

Immediate cause of death Carcinoma of Stomach — DURATION 2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings: Carcinoma of Stomach

Of operation — glands & gastro-hepatic

Of autopsy involved.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A Royce Hodges, M.D.

Address Cumberland M. D. or other

Date signed 8/10/40

850

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(93-d)

08253

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs.

Hospital, Institution, or street address where death occurred:

317 Central Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cumberland

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 317 Central Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Britty Powell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: Martin J. Powell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 22 1849

8. AGE: Years	Months	Days	If less than one day
90	9	18	..... hrs. ..... min.

9. Birthplace: Springfield W. Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Austin Biggs W. Va.

13. Birthplace

MOTHER — 14. Maiden name: Virginia Bias

15. Birthplace W. Va.

16. Informant: Martin L. Powell

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 13 '40 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Cumberland

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. Aug 13 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 10 1940, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 6 1939, to Aug. 10 1940 and that I last saw h[illegible] alive on Aug. 5th 1940

Immediate cause of death	DURATION
Myocardial degeneration	2 yrs
Due to: Old Age	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no

Date of op. —

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: J. J. Langston M. D. or other

Address: 5 E. n. Mech. Date signed: 8-12-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-74)

CERTIFICATE OF DEATH

08254

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (1)

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 yrs
Hospital, Institution, or street address where death occurred: 205 Columbia street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 205 Columbia St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Philip E Rank

3. (b) Social Security Number: 214-05-7062

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Ella Rank
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): 9/8/1874

8. AGE:

Years	Months	Days	If less than one day
63	11	19	hrs. min.

9. Birthplace: Lonaconing Md (Town, county, and state)
10. Usual occupation: Foreman
11. Industry or business: Cumberland Laundry Co
FATHER 12. Name: Lawrence Rank
13. Birthplace: Germany
MOTHER 14. Maiden name: Minnie Shade
15. Birthplace: Germany
16. Informant: John L. Baggett
Address: 205 Columbia St City
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/29/40 (month) (day) (year)
Cemetery or crematory: Hill Crest Cem.
Location: Cumberland Md
18. Funeral director: William H. Knight
Address: Cumberland Md
19. 8-29 1940 (Date rec'd by registrar) Joseph P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/27 1940, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1938 to July 1940 and that I last saw h. living alive on July 24 1940

Immediate cause of death: Carcinomatous (squamous cell epithelioma) of left tonsil & pharynx — DURATION 2½ yrs
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Emmett L Jones Jr M.D.
M. D. or other
Address: Date signed:

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

08255

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(8)

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 447 CUMBERLAND ST., CITY
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
BABY GIRL REED (STILLBORN)

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 15, 1940

8. AGE: Years (STILLBORN) Months Days If less than one day ..... hrs. ..... min.

9. Birthplace CUMBERLAND, MD.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name CARL L. REED
13. Birthplace NEW YORK

MOTHER
14. Maiden name NEOLA SACKREITER
15. Birthplace MINN.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MARYLAND

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Aug 15 1940 (month) (day) (year)

Cemetery or crematory Destroyed at hospital

Location

16. Funeral director

Address

19. Aug. 19 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 15, 1940, at 9:48 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AUG. 15, 1940, to AUG. 15, 1940 and that I last saw h..... alive on ..... 19.....

Immediate cause of death

Due to Intra uterine death 5 mos pregnancy

Due to Placental Prevention in mother

Other conditions

(Include pregnancy within 3 months of death)

DURATION: 1 week

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. L. Devers M.D. M. D. or other

Address Cumberland Md Date signed Aug 17-40

DR. HAWKINS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

08256

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: 957 Glenwood St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 69 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 957 Glenwood St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harry C Reger

705-09-9846

3. (b) Social Security Number None

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Mary E Billard

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 1871

8. AGE: Years 69 Months 5 Days If less than one day hrs. min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Retired 3 yrs Carman

11. Industry or business B & O Ry.

FATHER
12. Name Bolivar S Reger
13. Birthplace Unknown

MOTHER
14. Maiden name Eleanor Troxell
15. Birthplace Md.

16. Informant Robert E Reger

Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 13 1940 (month) (day) (year)

Cemetery or crematory Greenmount Cem.

Location Cumberland.

18. Funeral director Louis Stein Inc

Address Cumberland

19. Aug. 13, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1940, at 7 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1934, to Aug 12 1940 and that I last saw him alive on Aug 11 1940

Immediate cause of death Chronic myocarditis — DURATION About 1934

Due to Chronic Valvular heart disease — 1936

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Df operations No

Df autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury No Injured at work?

23. SIGNATURE [signature] M. D. or other

Address 133 Vale Date signed Aug 12 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

08257

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1014 Ella Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Sarah E. Rice

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: white

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Charles Rice

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): [illegible]

8. AGE: Years: about 60 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Hope West, Va.

(Town, county, and state)

10. Usual occupation: Home

11. Industry or business

FATHER

12. Name: John Johnston

13. Birthplace: West Va.

MOTHER

14. Maiden name: Not Known

15. Birthplace

16. Informant: Mr Charles Rice

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 7 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland Md

18. Funeral director: Louis Stein Inc

Address: Cumberland Md

19. Aug 7 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5 1940, at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 1940 to Aug 5 1940 and that I last saw h. ex alive on Aug 5 1940

Immediate cause of death	DURATION
Anomalous Tuberculosis	?
Due to: Myocardial Disease	?
Coronary Artery disease	-
Due to	
Other conditions: Pleural Effusion	?
Possibly Tubercular	?

(Include pregnancy within 3 months of death)

Major findings of operations: Pleural Effusion (Lab results not in yet) Date of op. Aug 4, 1940

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Samuel M. Jacobson Mgr. M. D. or other

Address: 119 Bradford St Date signed 8/6/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

08258

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Allegany County Home
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
Mr. George Rider

3. (b) Social Security Number
None

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 23 1868

8. AGE: Years 72 | Months 2 | Days 9 | If less than one day ..... hrs. ..... min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Frank S Rider
13. Birthplace Pa

MOTHER
14. Maiden name Florence Orndt
15. Birthplace Ill

16. Informant Mrs Alice Evans.
Address 211 W. 2nd St City.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Aug 3 40
(month) (day) (year)

Cemetery or crematory St P & P. Cem.

Location Cumberland

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Aug 3 1940 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 1940, at 1:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from A.M. 1-1 1940, to 8-2-1940 and that I last saw him alive on 8-1-1940

Immediate cause of death: Arteriosclerosis — DURATION ?

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm F. Williams M. D. ~~or other~~

Address Cumberland Date signed 8-2-40

Dr W. F. Williams

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 6 1940
BUREAU V. S.

Outside of City Limits

08259

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: La Vale
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 20 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: La Vale
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Ruhlin James Ritchie

3. (b) Social Security Number: 214-16-2597

4. Sex: M
5. Color or race: W
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Grace Ritchie
6(c) If alive, give age: 35 years
7. Birth date of deceased (mo., day, yr.): December 10 1909
8. AGE: Years 30 | Months 8 | Days 27 | If less than one day ___ hrs. ___ min.
9. Birthplace: Elkins, Randolph Co W.Va (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Building Houses
FATHER
12. Name: John W. Ritchie
13. Birthplace: Franklin WVa
MOTHER
14. Maiden name: Sexie Seter
15. Birthplace: Franklin WVa
16. Informant: John W Ritchie
Address: La Vale, Cumberland Md
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug 10/40 (month) (day) (year)
Cemetery or crematory: Ritchie Cemetery
Location: Macksville WVa
18. Funeral director: William H. Kight
Address: Cumberland Md
19. Aug. 8 1940 (Date rec'd by registrar) J. S. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 7th 1940, at 6:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1940, to Aug 7 1940, and that I last saw him alive on Aug 5 1940.

Immediate cause of death: Intestatic Carcinoma of Lungs
Due to: Primary Lesion Gluteal Muscle
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

DURATION: 8 mo. 9 mo.

Major findings:
Of operations: Malignancy of Lung mass removed from Gluteal region.
Of autopsy:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. C. Bowen M.D. M. D. or other
Address: Cumberland Md Date signed: 8-8-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

08260

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 975 Williams Road.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 975 Williams Road.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harrison Robinette

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Mary Frances Bucy

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Oct 27 1866

8. AGE:

Years	Months	Days	If less than one day
73	9	26	....hrs. ....min.

9. Birthplace: Allegany County, Md.
(town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farm

FATHER
12. Name: Zatham Robinette
13. Birthplace: Allegany Co, Md.

MOTHER
14. Maiden name: Mary Shaw
15. Birthplace: Allegany Co, Md.

16. Informant: Mrs. Harrison Robinette
Address: 975 Wms. Rd. Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 26 1940 (month) (day) (year)

Cemetery or crematory: Mt. Hermon

Location: Williams Rd - Near Cumberland

18. Funeral director: Jacob Hafer.

Address: Cumberland, Md.

19. Aug 26 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 23 1940, at 11½ 15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 23 1939, to Aug 23 1940 and that I last saw him alive on March 1 1940

Immediate cause of death	DURATION
Coronary Thrombosis	1 hrs
Due to	
Due to	
Other conditions: Carcinoma of rectum	1 yrs

(Include pregnancy within 3 months of death)

Major findings of operation: Carcinoma of rectum by biopsy — Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Samuel A. Jacobson M. D. or other

Address: 119 Bedford St. Date signed: Aug 26/40

Dr Jacobson

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (121)

CERTIFICATE OF DEATH

08261

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 5 hr. 20 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town LUKE
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
RICHARD RODRIGUEZ

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUGUST 20, 1938

8. AGE: Years	Months	Days	If less than one day
2	0	3	hrs. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation CHILD

11. Industry or business

FATHER
12. Name JOSEPH RODRIGUEZ JR.
13. Birthplace SPAIN

MOTHER
14. Maiden name MARGARET BRANDLEN
15. Birthplace MARYLAND

16. Informant Mrs. Joseph Rodriguez Jr.
Address Luke Md.

17. Burial
(Burial, cremation, or removal Which?) Date thereof Aug. 26. 1940
(month) (day) (year)

Cemetery or crematory Phillips Cem

Location Westernport Md.

18. Funeral director David S. Boal

Address Westernport Md.

19 Aug 23 19 40 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 3:35 P.M

20. DATE OF DEATH AUGUST 23, 19 40, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 23 19 40, to Aug. 23 19 40

and that I last saw h.. alive on Aug. 23 19 40

Immediate cause of death Gangrenous + Ruptured Appendix — DURATION 3 days
Generalized Peritonitis — 2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Ruptured, Gangrenous Appendix — Date of op. 8/23/40

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. H. Eliason M.D.
M. D. or other

Address 126 Union St. Cumberland Date signed 8/23/40

DR. F. WILSON & ELIASON

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

08262

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (121)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 502 S. Paca St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Vincent Bernard Rybikowsky

3. (b) Social Security Number 213-14-8918

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary Regina Goulden

6.(c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) Aug 9 1910

8. AGE:

Years	Months	Days	If less than one day
30	—	3	hrs. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual occupation Tailor – circus performer

11. Industry or business

FATHER
12. Name Casper Rybikowsky
13. Birthplace Russia

MOTHER
14. Maiden name Eufrozina Batora
15. Birthplace Russia

16. Informant Mrs Mary R. Rybikowsky
Address 502 S Paca St Baltimore Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 13, 40 (month) (day) (year)

Cemetery or crematory St. Peter & Paul's

Location Cumberland Md.

18. Funeral director Louis Steinhe
Address Cumberland Md.

19. Aug 13 19 40 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 19 40 at 10 00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/6/40 19 to 8/12/40 19 and that I last saw h[illegible] alive on 8/12/40 19

Immediate cause of death General peritonitis

Due to Ruptured appendix.

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations Laparotomy – peritonitis Date of op. 8/7/40

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John K Rozner MD M. D. or other

Address Cumberland Md Date signed 8/13/40

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83f)

CERTIFICATE OF DEATH

08263

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 202 Laing Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 202 Laing Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Agnes A Sarver

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Winfield Sarver
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 6 1886

8. AGE: Years: 54 | Months: 1 | Days: 10 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Morgantown, West Va.
(Town, county, and state)

10. Usual occupation: Home

11. Industry or business

FATHER
12. Name: William Hennessey
13. Birthplace: West Va.

MOTHER
14. Maiden name: Virginia Comell
15. Birthplace: West Va.

16. Informant: Mr Winfield Sarver
Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 19 40 (month) (day) (year)
Cemetery or crematory: Davis memorial
Location: Cumberland Md.

18. Funeral director: Davis Stein Bro.
Address: Cumberland, Md.

19. Aug 19 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 16 1940, at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 16 1940, to August 16 1940, and that I last saw her alive on August 16 1940.

	DURATION
Immediate cause of death	
Cerebral Embolism	2 hours
Due to (Cause unknown)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. B. Mc. Cay M.D. (M. D. or other)
Address: Cumberland Md. Date signed: Aug 17 1940

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14-B)

CERTIFICATE OF DEATH

08264

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cushbert Land

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 3 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Oakland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Third St

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Sines, Stella

3. (b) Social Security Number: 213-18-2998

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 2, 1916

8. AGE:

Years	Months	Days	If less than one day
23	11	0	hrs. min.

9. Birthplace: Hoyes Run Md (Town, county, and state)

10. Usual occupation: Relief Worker

11. Industry or business:

FATHER

12. Name: Charles C. Sines

13. Birthplace: Oakland, Md

MOTHER

14. Maiden name: Mary Sisler

15. Birthplace: Oakland, Md

16. Informant: Charles C. Sines

Address: Oakland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 4 - 1940 (month) (day) (year)

Cemetery ~~or crematory~~: Oakland Md

Location: Oakland Md

18. Funeral director: Emroy Bolden

Address: Oakland Md

19. Aug 2 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 2, 1940, at 12:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30, 1940, to 19, and that I last saw her alive on 8/1/40. 19

Immediate cause of death	DURATION
Ruptured Tubal pregnancy	
Due to Exsanguination.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: Ruptured left tube - due to pregnancy

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. L. K. Kozun M.D. M. D. or other

Address: Cumberland Md Date signed: 8/2/40

RECEIVED
AUG 24 1940
BUREAU V. S

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08265

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1009 Gay St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James Smith

3. (b) Social Security Number 213-18-2452

4. Sex: Male

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Julia Moore.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 1, 1885

8. AGE: Years 55 | Months 8 | Days 5 | If less than one day ..... hrs. ..... min.

9. Birthplace: Atlanta, Georgia.
(Town, county, and state)

10. Usual occupation: W.P.A.

11. Industry or business

FATHER
12. Name: James Smith.
13. Birthplace: Georgia.

MOTHER
14. Maiden name: unknown Maggie Ellis
15. Birthplace: Atlanta Georgia

16. Informant: Mrs J M Smith.
Address: Cumberland. Md.

17. Burial. Date thereof: Aug 9 40
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Summers Cemetery

Location: Cumberland. Md.

18. Funeral director: Louis Stein Inc.
Address: Cumberland, Md.

19. Aug 8, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6 1940, at 6:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 2 1940, to August 6 1940 and that I last saw him alive on August 6 1940

Immediate cause of death: Gastric Crisis due to cerebrospinal syphilis Luetic aortitis

DURATION: 3 days

~~Due to~~ aortic insufficiency mitral stenosis & insufficiency

~~Due to~~ Hypertension, chronic nephritis, uremia

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results: Luetic aortis, aortic insufficiency

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Samuel A. Jacobson M.D. M. D. ~~or other~~

Address: 119 Bedford St. Date signed: 8/7/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1940
BUREAU V. S.

08266

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH:

County Allegany

City or town Ellerslie
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Ellerslie
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME LEAH NITA SMITH

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	WIDOWED

6.(b) Name of husband or wife Harrison G. Smith

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 23, 1891

8. AGE: Years	Months	Days	If less than one day
49	1	22	..... hrs. ..... min.

9. Birthplace Hyndman Bedford Penna.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Samuel Kendall
13. Birthplace Pa.

MOTHER
14. Maiden name UNKNOWN
15. Birthplace

16. Informant Robert K. Smith
Address Ellerslie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 18, 1940 (month) (day) (year)

Cemetery or crematory Hyndman Cemetery

Location Hyndman, Penna.

18. Funeral director Harvey H. Zeigler
Address Hyndman Pa.

19. Aug 17 1940 (Date rec'd by registrar) J. Lloyd Wolfe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1940, at 8A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1940, to Aug 15 1940 and that I last saw h. E.R. alive on Aug 15 1940.

Immediate cause of death	DURATION
Angina Pectoris	1 hour
Due to	
Due to	
Other conditions Hyperthyroidism	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A. Tupper M. D. ~~or other~~

Address Hyndman, Pa Date signed 8/16/40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 10 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (127-a)

08267

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: Memorial Hosp.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 322 Paca St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Eleanor Snyder

3. (b) Social Security Number None

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 9, 1900

8. AGE: Years 39 Months 9 Days 2 If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home

FATHER
12. Name John L. Snyder
13. Birthplace Md.

MOTHER
14. Maiden name Nora Widenour
15. Birthplace Md.

16. Informant Memorial Hosp.
Address Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 13, 1940 (month) (day) (year)

Cemetery or crematory Rose Hill Cem

Location Cumberland, Md.

18. Funeral director V. L. Lumpkeur
Address Cumberland, Md

19 Aug 12th 18, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

850

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11 1940, at 3 20 AM

21. CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 1940, to Aug 11 1940, and that I last saw h alive on 19

Immediate cause of death Cirrhosis of liver ?

DURATION ?

Due to

Due to

Other conditions Subdiaphragmatic abscess — Chronic Cholecystitis
(Include pregnancy within 3 months of death)

Major findings: Large fibrotic area in liver. Chronic Cholecystitis

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Royce Hodges, M.D. M. D. or other

Address Cumberland, Md Date signed 8/12/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(T)

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(92-d)

08268

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 429 Homer St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 429 Homer St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Katherine Carolyn Squires

3. (b) Social Security Number None

4. Sex: female

5. Color or race: white

6.(a) Single, married, widowed, or divorced: widowed

6.(b) Name of husband ~~or wife~~ John E. Squires

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1869

8. AGE: Years	Months	Days	If less than one day
71	9	12	..... hrs. ..... min.

9. Birthplace Germany
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name John Kiffner
13. Birthplace Germany

MOTHER
14. Maiden name Elizabeth Hartung
15. Birthplace Germany

16. Informant Warren Squires
Address 429 Homer St.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Aug 29 1940
(month) (day) (year)

Cemetery or crematory Greenmount

Location Cumberland, Md

18. Funeral director Louis Stein Inc
Address Cumberland, Md

19. Aug 26 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1940, at 6 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 18 1940, to Aug. 23 1940 and that I last saw h. lx alive on Aug. 23 1940

Immediate cause of death	DURATION
Cerebral Embolism	5 days
Due to Chronic Endocarditis	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. L. Gleason M.D.
M. D. or other

Address 1262 Hill St. Cumberland Md. Date signed 8/24/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08269

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution or street address where death occurred: Memorial Hospital

How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. WILLIAMS ROAD RT#2

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MR. CHARLES H. STAFFORD

3.(b) Social Security Number 212-12-8810

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife BESSIE BLUBAUGH

6.(c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) NOVEMBER 30, 1887

8. AGE: Years	Months	Days	If less than one day
52	8	21	hrs. min.

9. Birthplace WEST VIRGINIA (Town, county, and state)

10. Usual occupation W.P.A. WORKER

11. Industry or business

FATHER 12. Name GEORGE STAFFORD (DECEASED)

13. Birthplace West Virginia

MOTHER 14. Maiden name MARTHA BUCY

15. Birthplace MARYLAND

16. Informant Mrs. Bessie Stafford

Address R.D.#2. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 25, 1940 (month) (day) (year)

Cemetery or crematory Mt. Herman Cem.

Location Williams Road

18. Funeral director J. C. Wolford

Address Cumberland, Md.

19. Aug 25 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION 9:45 A.M

20. DATE OF DEATH AUGUST 22 1940, at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 21 1940, to August 22 1940

and that I last saw him alive on August 22 1940

Immediate cause of death	DURATION
Chronic Myocarditis	2 years.
Due to (Rheumatic)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Broadrup M.D. M. D. or other

Address Cumberland, Md. Date signed 8-22-40

DR. BROADRUP

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

CERTIFICATE OF DEATH

08270

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

Street No. LaVALE
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME

BABY GIRL STATLER

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	NEW BORN

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) AUG. 13, 1940 12:56 A.M.

8. AGE: Years	Months	Days	If less than one day
			2 hrs. 24 min.

9. Birthplace MEMORIAL HOSPITAL
CUMBERLAND, MD.
(City, town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name GEORGE STATLER
13. Birthplace MARYLAND

MOTHER
14. Maiden name THELMA DYCHE
15. Birthplace MARYLAND

16. Informant MRS. GEORGE STATLER
Address LaVALE, MD.

17. Cremated (Burial, cremation, or removal. Which?) Date thereof Aug. 13, 1940 (month) (day) (year)

Cemetery or crematory Destroyed at Hospital

Location

18. Funeral director

Address

19. Aug 15 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 13, 1940 at 2:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 13, 1940, to Aug. 13, 1940

and that I last saw h— alive on Aug. 13, 1940

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clark L. Jones M. D. or other

Address Cumberland Date signed Aug. 15, 1940

DR. DURRETT

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-3)

CERTIFICATE OF DEATH

08271

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 214 Fulton Street

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 16 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 214 Fulton Street (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Hugh Stevenson

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Mary Douglas

6(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): Oct. 31, 1860

8. AGE: Years: 79 | Months: 9 | Days: 5 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Scotland (Town, county, and state)

10. Usual occupation: Retired Weigh Master

11. Industry or business: Coal Mine

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Scotland

16. Informant: Miss Sara Higgins

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 8th 1940 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md.

18. Funeral director: J. M. Sidebottom

Address: Lonaconing, Md.

19. Aug 6, 1940 (Date rec'd by registrar) J. D. Braklai, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6 1940, at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15 1940, to Aug. 6 1940, and that I last saw him alive on August 6 1940.

	DURATION
Immediate cause of death: Endo-Carditis	1 7/15/40
Due to: Influenza	7/15/40
Due to:	
Other conditions: Chronic Nephritis with Hypertension (Include pregnancy within 3 months of death)	?

Major findings:

Of operations:

Of autopsy:

PHYSICIAN — Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ____ Injured at work?

23. SIGNATURE: L. J. Lanich M. D. or other

Address: Cumberland Md. Date signed: 8-6-40

RECEIVED
SEP 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08272

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Allegany

City or town Frostburg Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ohio County Mahoning

City or town Youngstown Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Wm. D. Stevenson

3. (b) Social Security Number 278-10-0833

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lillie Porter Stevenson

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE:

Years	Months	Days	If less than one day
44			hrs. min.

9. Birthplace Frostburg Md.
(Town, county, and state)

10. Usual occupation Steel Worker

11. Industry or business

FATHER 12. Name John Stevenson

13. Birthplace Midland, Md

MOTHER 14. Maiden name Belle Beasgang

15. Birthplace Midland Md.

16. Informant John Stevenson

Address Midland Md.

17. Removal Date thereof Aug. 26 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Belmont Park Cem.

Location Youngstown Ohio

18. Funeral director Jacob Kafer

Address Frostburg, Md.

19. Aug. 26 19 40 Nancy A. Rae Dist. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24th., 1940, at about 8:30 A. M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19,

and that I last saw h alive on 19.

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Prince H. Johnson M. D.

M. D. or other

Address Cumberland, Maryland. Date signed 8/24/40

Deputy Medical Examiner - Allegany Co.

RECEIVED
SEP 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 2

CERTIFICATE OF DEATH

(97)

08273

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Flintstone (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 82 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany

(c) City or town Flintstone Star Route (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Daniel Franklin Stewart

3 (b) If veteran, name war

3 (c) Social Security No. none

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. married.

6 (b) Name of husband or wife Sarah Jane Kifer

6. (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) Dec 27. 1857

8. **AGE:** Years 82 yr. Months 7 Days 4 If less than one day hr. min.

9. Birthplace Allegany Co Md. (Town, county, and state)

10. Usual occupation Labour.

11. Industry or business Farm

FATHER 12. Name John Stewart

13. Birthplace Flintstone, Md

MOTHER 14. Maiden Name Bukie Fletcher

15. Birthplace Champsville Pa.

16 (a) Informant Mrs D F Stewart

(b) Address Flintstone Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 3 1940 (month) (day) (year)

(c) Cemetery or crematory Glendale

Location Flintstone, Md.

18 (a) Funeral director Jacob Hafer

(b) Address 230 Baltimore Ave.

19 (a) Aug 3-40 (Date rec'd by registrar) (b) D. Bennett Registrar

MEDICAL CERTIFICATION

20. Date of death Aug 1st 1940, at 11 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 12th 1940, to Aug 1st 1940, and that I last saw him alive on July 31st 1940.

Immediate cause of death Arteriosclerosis

Due to Old Age

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Dr. A. P. Trigg M. D. of other

Address Flintstone Md Date signed Aug 1st 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 4 1949
Bureau of V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08274

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 76 Mechanic St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State ____ County ____

City or town ____ Ward No. ____
(If outside city or town limits, write RURAL NEAR and give town)

Street No. ____
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ____

3. (a) FULL NAME Infant Thorp

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife ____

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Stillborn 8/11/40

8. AGE: Years | Months | Days | If less than one day ____ hrs. ____ min.

9. Birthplace: Frostburg, Md.
(Town, county, and state)

10. Usual occupation ____

11. Industry or business ____

FATHER
12. Name: Carl Wm. Thorp
13. Birthplace: Frostburg Md

MOTHER
14. Maiden name: Fawn Shirtz
15. Birthplace: Frostburg Md

16. Informant: Carl Wm. Thorp

Address: 76 Mechanic St.

17. ~~Burial~~ Cemetery Date thereof: 8/12/40
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Lutheran Cem.

Location: Frostburg Md

18. Funeral director: Jacob Nafer

Address: Frostburg, Md.

19. Aug. 12 1940 Nancy H. Roe Dept.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 11 1940, at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 11 1940, to Aug 11 1940, and that ~~I last saw him alive on~~ ____ 19____.

Immediate cause of death: Stillbirth

Due to ____

Due to ____

Other conditions ____
(Include pregnancy within 3 months of death)

Major findings:

Of operations ____

Of autopsy ____

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work? ____

23. SIGNATURE: A. M. Earle
M. D. or other

Address: 60 W Main ST Date signed 8-12-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

CERTIFICATE OF DEATH

08275

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 407 Cumberland St.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 407 Cumberland
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mollie N. Topper

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr. 6, 1870

8. AGE: Years	Months	Days	If less than one day
70	4	18	hrs. min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business

FATHER
12. Name: A. J. Topper
13. Birthplace: Maryland

MOTHER
14. Maiden name: Hannah Waldron
15. Birthplace: West Va.

16. Informant: Mrs. John J. Howe
Address: 407 Cumberland St. Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 27, 1940 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland, Md.
18. Funeral director: J. C. Wolford
Address: Cumberland, Md.

19. Aug. 27 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 24, 1940, at 10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1940, to Aug 24 1940, and that I last saw her alive on Aug 24 1940.

	DURATION
Immediate cause of death: Uraemia Coma	7 Days
Due to: Organic Heart Disease	3yrs
Due to: Chronic Nephritis	3yrs
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. P. Franklin M. D.
M. D. or other
Address: Cumberland Md. Date signed 8/26/40

RECEIVED
SEP 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92d

08276

Reg. Dist. No.

1. PLACE OF DEATH:

County: Allegany

City or town: Little Orleans (rural near)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or insl. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 64 yrs. 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Little Orleans (rural) Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: R.F.D. 1
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Clarissa Ellen Watson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Married

6 (b) Name of husband or wife: Ezra J. Watson

6(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): August 7, 1876

8. AGE: Years	Months	Days	If less than one day
64	—	20	— hrs. — min.

9. Birthplace: Piney Grove, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: Own home

FATHER 12. Name: Henry Mann

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Margaret Foster

MOTHER 15. Birthplace: Pennsylvania

16. Informant: Floyd E. Watson

Address: Hancock, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 30, 1940 (month) (day) (year)

Cemetery or crematory: Piney Plains Cemetery

Location: Little Orleans, Md. (rural)

18. Funeral director: Ephraim Smith

Address: Artemas, Pa.

19. Aug 28 1940 (Date rec'd by registrar) T. T. Mann (Registrar) M.E. Mann

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 27 1940, at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 29 1940, to Aug. 27 1940, and that I last saw her alive on Aug. 27 1940.

Immediate cause of death	DURATION
Chronic Myocarditis	8 mo
Endocarditis, Chronic.	
Due to Duration: four months. Cured.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. A. Watson M.D.
M. D. or other

Address: Little Orleans, Md. Date signed: Aug 29, 1940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

SEP 7 1940
U. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

08277

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 305 N Mechanic St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Girl Wickard

3. (b) Social Security Number None

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 10, 1940

8. AGE: Years Newborn | Months | Days | If less than one day hrs. 15 min.

9. Birthplace Cumberland, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Sylvester Wickard
13. Birthplace Cumberland, Md.

MOTHER
14. Maiden name Frances Mears
15. Birthplace Maryland Frostburg

16. Informant Sylvester Wickard
Address Cumberland

17. Burial (Burial, cremation, or removal, Which?) Date thereof Aug 12, 1940 (month) (day) (year)

Cemetery or crematory Rose Hill

Location Cumberland Md

18. Funeral director Jacob Hafer
Address Cumberland, Md

19. Aug 12, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10, 1940, at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,

and that I last saw h alive on 19

Immediate cause of death Premature + hemorrhage (~~[illegible]~~) of mother due to premature seperation of placenta

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. C. Bowen M.D. M. D. or other

Address Date signed

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

CERTIFICATE OF DEATH

08278

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 107 South St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State: Md County: Baltimore City

City or town: Baltimore, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3520 Woodlawn Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Cora Jane Wright

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife: Eugene C. Wright

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November 15, 1873

8. AGE: Years	Months	Days	If less than one day
66	9	3	..... hrs. ..... min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: John B. Ward

13. Birthplace: W. Va.

MOTHER — 14. Maiden name: Rachael Kerns

15. Birthplace: W. Va.

16. Informant: Chester W. Wright

Address: 3520 Woodlawn Ave. Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 20. 40 (month) (day) (year)

Cemetery or crematory: Green Brad Cem

Location: Westminster, Md.

18. Funeral director: Louis Stein Inc

Address: Cumberland, Md.

19. Aug. 18 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 18 1940 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 8 1940 to Aug 18 1940

and that I last saw h.. alive on Aug 8 1940

Immediate cause of death: Coronary Occlusion — DURATION

Due to: Arteriosclerosis

Due to:

Other conditions: Reported to Medical Examiner (Include pregnancy within 3 months of death)

Major findings of operations:

No Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. B. Owen M. D.

Address: 133 Va Date signed: 8/19/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
AUG 28 1940
BUREAU V.R.